SAHTU HEALTH AND SOCIAL SERVICES AUTHORITY (SHSSA)

2014-2016 STRATEGIC PLAN

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SAHTU'S ESTHER:

HOW REDESIGNING CARE AND SERVICES AROUND WHAT 'ESTHER' NEEDS, CHANGES EVERYTHING.

Esther is exhausted. She can hear her two little grandsons in the kitchen scrounging for something to eat. She knows she should get up but knows the throbbing headache she has now will be pounding once her feet hit the floor. "They'll manage" she says to herself. Manage or perish is kind of how it is around here.

She promised herself this month's cheque wouldn't be used to buy booze. She would have kept that commitment if her youngest son hadn't showed up yesterday. Another bad week for Albert. He struggles with depression. It gets so bad she worries he will someday just give up. She has seen so many young men in Fort Good Hope commit suicide she shudders to think what Albert may do if things don't turn around for him. Esther knows alcohol isn't the solution to her son's depression, it dulls the pain for a while. She knows her sugar will be bad today after all that they drank last night. At least there is no reason to poke my finger, she thinks. I know what the number will be.

She remembers she's supposed to go to the clinic today. Marie called to tell Esther about the appointment they have for her. Something about a new diabetic program. Esther's heard that before. The nurses and doctors at the clinic are more concerned about my blood sugars than I am. They don't have the rest of the stuff to worry about that I do. Finding money somehow to pay this month's rent plus last month's power and that damn collections agent threatening to take my pickup back if I don't come up with my payments before the end of the month. Let him come and try and find that truck. Good luck.

She hears the toddlers pulling a chair up to the kitchen cupboard looking for cereal to eat. She really should get up; those boys are too little to be climbing. "Why are they here with me?" she wonders. The memory is unclear but she thinks her daughter dropped them off late last night. Her son-in-law got some alcohol from George the bootlegger and Elizabeth was worried for the children's safety. If I don't get my fat ass out of bed, they might fall and that would be awful. Esther pulls back the covers and slowly gets up. The room spins for a while, her head feels like it's going to explode; her mouth is dry, sweat under her arms dripping. She steadies herself on the edge of the dresser until her head clears and then moves toward the kitchen.

Later in the morning, she's feeling better. She found some caribou meat to eat and had some tea so her heart isn't racing quite so badly and she is no longer sweating. She needs to get to the clinic. Maybe one of those lazy home care workers could pick me up, she thinks. They pick up Doris when she needs a ride to the clinic. Why not me, I need a ride. "You're not on our list", they'll say. How do you get on the god damned list, anyway? Helps if you're a friend of a relative, I guess. She looks out the window, the sun is bright though the air looks cold, no wind. She will walk to the clinic even though it

will mean she'll be late for her appointment again. Sue me, she thinks – who cares other than you if I'm late or on time?

Esther's surprised by what she sees at the clinic this morning. There is a big sign over the clerk's desk saying the 'Cassien Edgi Health Centre exists to serve the people of Fort Good Hope so they can achieve physical, mental and spiritual wellbeing as individuals, families and community'. Humph, that's a new idea. They will serve me? Seems to me with all of these appointments they set up for my diabetes that I'm serving them with my blood!

Another surprise, that counsellor I've been trying to get my son to see is here in the waiting room just visiting. I don't think I've ever seen him outside of his office in the two years he's been in Fort Good Hope. I wonder what's going on.

Marie asks me if my phone number has changed lately. I don't remember her ever asking me that before. I do have a new number. My daughter Bella thought I should cancel my home telephone when she gave me her cell phone. I tell Marie the new number and turn to go sit in the waiting room. "Esther?" she calls, "would you like a tea while you're waiting?" Wow, they really are going to serve me.

Arlene is the nurse's name. She says we've met before but I can't remember them all. Arlene is quite excited today. She says the staff are working on three new programs to work in each community. Diabetes, addictions and home care are the three, Arlene says. "We're meeting with everyone in Fort Good Hope that has high blood sugars or diabetes", Arlene explains. "We want to know from each person what the most important aspect of their health – mental, physical or spiritual health, which is most important to you, Esther?"

I don't know what's she's talking about – health? I don't know if I've ever really thought about my health. They told me I was diabetic when I was pregnant with my second child. I had another four after that, all huge babies that looked so odd in the nursery they have in Yellowknife for babies who aren't doing so well when they're first born. What's my goal for health? How do I even begin to think about that? I would like to say to her, I want enough money that I don't have to worry every month if I can pay my bills. I would like to tell Arlene that I'd like someone to take my son out on the land so he can feel the peace of the creator and know he is worthy. I'd like someone to help me look after ?Ahso, she's driving me crazy with all of her demands. I know she's lonely and scared, hell, I'm scared.

"I don't know what I want" I tell the enthusiastic nurse. I'm so tired. "My kids aren't doing well," I say. "They are always at me to rescue them. How can I rescue them when I can't even take care of myself?"

"Tell me about your kids, Esther" she says.

An hour later I emerge from the nurse's office with red eyes and a list of ideas Arlene and I have made of options for my kids and for me. As I stood up to leave, Arlene says

to me "is there anything else I can help you with today?" I want to know what they're putting in the tea around here – the staff seems to really care.

"No," I say, "I really appreciate you listening to my story, I can't remember the last time someone just listened to me." She promises to meet me at my mother's house on Friday so we can talk to her about some options too.

Junior is just getting up when I get back to the house. He doesn't look good. Doesn't smell very good either. "I think there's enough water for a shower" I say to him. He looks at me with eyes that are barely open and heads for the shower.

I call my mother. "?Ahso", I say. "The nurses at the clinic are looking at how they can improve home care, they want to talk to you".

"I don't get no home care, I'm not on the list" she says.

"I told her that and I told her you weren't doing so well all alone. She says they are going out and meeting all the elders and talking about options. I told her we could meet at your house on Friday." I wait for her to process this. She will be pleased to have someone visit but she won't say so.

"What do they want to talk to me about?" she grumbles.

"Options" I say. "It's the new word they are using with everyone. They say they want to talk to you about what options you might like. I don't know what they're talking about. I know you wanted to know how you get them to give you a ride sometimes. I also know you would like to play bingo again. Maybe those are some of the options."

"When on Friday?" she says with more interest.

"Eleven" I reply.

Junior emerges from the bathroom smelling like soap, a big improvement over the smell he went in with. His eyes are a little clearer. I boil water for tea. "The nurse at the clinic says they are starting a men's on the land program" I tell him.

"Nurses don't know nothing about the land" he says. "I don't need any nurses hounding me in town or out on the land".

"It's for young men with addictions. Charlie is working with the counsellor to set it up" I say. "I think you should think about it". He gives me a dark look and heads for the bedroom, slamming the door behind him. I pour the water for the tea and think about Charlie.

Charlie had a worse time at residential school than me or my brothers or sisters. As a young man, Charlie seemed determined to bury himself with booze. He's been through more treatment programs than you could count. He would get dry down south and then as soon as he came back it was back to the booze. It looks like once he had to figure

out how to manage his drinking back here in Fort Good Hope. If he's helping with a program for young men, I think Albert would do well to give it a try. Albert really missed out on having a strong man to look up to. The older boys had my dad before he passed. Albert only had his deadbeat drunk dad to follow around and haul home when he passed out.

"How can I help you today, Esther?" Again with the kindness, what's up with these people? I'm back at the clinic today. This time I'm seeing the social worker for the first time. My kids won't have anything to do with her because she's the one that takes your kids if your caught drinking. Normally you have to go see her at the other building – no one likes to go there because they think you have to be crazy or a drunk to see anyone there. Arlene told me the social worker would see me anywhere I wanted her to – my house, the clinic or the wellness centre. I figured the clinic wouldn't stir up any talk. No one will be surprised to see me go into the clinic.

"The nurse says you might be able to help me with the bills I can't pay", I say. I didn't believe Arlene when she said the social worker might be able to help. I know they help elders with forms to fill out but I've never heard them working with people who have bad debts.

"Well let's start with looking at the money you have coming and the money you have going out every month" she says. I've brought some of my bills and cheque stubs so she can help me figure out what I might be able to do to get out from this mess I'm in. Arlene surprised me when she said that sorting out my bills so I didn't have to worry about my power getting cut off or getting evicted from housing was a good start on a goal for my health.

"?Ahso, why are you still in bed?" I say. The nurse, counsellor and home support worker are in the living room. I think my mother is doing this on purpose. "Get up, we have people here" I say to her in Slavey.

"Rose, we're here to learn how things are going for you. We have a few questions and then we hope you will ask us lots of questions. My name is Arlene, I'm one of the nurses at the clinic. I share my job with a nurse named Claudette. You may have met her, she has a Neufie accent. This is James, he's a mental health counsellor and you probably know Monette, the home support worker". My mother nods and sits in her favorite chair. I bring her some tea with lots of sugar, just the way she likes it.

Arlene says they've been going around interviewing all the elders in the community and anyone else who will need some help at home to keep them safe and well in their own homes. My mother is one of the last they are interviewing. With all the information they've collected they will be looking at the programs and services that people think they need and then make some decisions. It's not just the health centre staff that will be making the decisions. There's going to be a committee made up of three people from the community and three from health and social services. I won't hold my breath. I've seen many committees try and do things differently for the people.

What I like from the interview was the counsellor speaking up about elder abuse. It's a big problem in Fort Good Hope. Everyone knows when the old age cheques come in the mail. Kids and grandkids are all of a sudden visiting and offering to help. My oldest son Elwood is bad for this. ?Ahso likes him to visit but not just to get money from her. She depends on him to get the moose hide she needs to make her beaded vests. She can't say no to him but she can't get through the month any better than I can if she gives him any money. James says he's working with the RCMP, the social worker and the chief on the elder abuse problem. Seems they have some ideas from other communities where they've had some success of reducing the problem.

Some of the ideas the committee is thinking about is a day program for elders at the wellness centre. Hot lunch and bingo with fruit and vegetables for prizes is the idea they are thinking about. ?Ahso perked up at that idea. ?Ahso asked how many times a week they would play bingo.

The clinic people also said they might get out of transportation support all together. The clinic staff plans to be making more visits to people's homes so there won't be as much need to bring Elders to the clinic. It takes up too much time of the home support workers and it's too hard to provide it to everyone. The clinic is partnering with the band office to see if this is a service the band could take over.

No one has asked me about my blood sugar all week. I know it's down from where it usually is. I can feel it. The social worker gave me some ideas of how I can pay my bills and Albert has an appointment with Charlie and James to see about the men's out on the land program. If ?Ahso goes to bingo even twice a week it will mean two days that she's not calling me complaining about her back or her shoulders or whatever other body part is aching. I finally feel like maybe I could think about my health now. What would my goal be? I'd like to be able to paddle a canoe again. Maybe I could even teach my grandsons.

STEP ONE: CHANGE BEGINS AT THE TOP.

By walking in Esther's shoes (and all the other Esther's and Albert's, Elwood's and ?Ahsos') leaders and staff of Sahtu Health and Social Services Authority (SHSSA) are able to rethink and redesign how to support health and social wellbeing for people living in the five communities of the Sahtu.

SHSSA Board Members initiated this transformation by first sharing their own personal stories of discovering wellbeing. Overcoming abuse and addictions, taking charge of their health, considering the long term needs of the people they loved. Their stories were as unique as they are similar. Their stories speak of the strength of resolve that had to come from within each person. The support they needed to change came from health and social services personnel who provided options more than advice. Staff that made a difference demonstrated genuine care by working to understand what mattered most to them as individuals. Listening, more than talking, was key.

SHSSA Mission:

PEOPLE, FAMILIES AND COMMUNITIES OF THE SAHTU ARE MENTALLY, EMOTIONALLY, SPIRITUALLY, PHYSICALLY AND CULTURALLY HEALTHY.

SHSSA Board Members developed the following Guiding Principles to direct the transformation in care they want to see in practice.

GUIDING PRINCIPLES FOR SHSSA IN PROVIDING CARE AND SERVICES TO ESTHER:

- Care and services based on relationships with people and families.
- Care and services provided where individual is at – Bring care to the people.
- Care and services as an integrated team based on needs of patient and family.
- Care that respects culture.
- Care and services delivered through partnerships with individuals, families, community agencies and communities.
- Provide people with options – support self-management.
- Healthy staff is in a better position to provide relationship based care.
- Have useful measures to monitor if what we are doing is making a difference in the health and social wellbeing of Sahtu people.

STEP TWO: SET CLEAR EXPECTATIONS FOR FUNDAMENTAL CHANGE

After reviewing the key recommendations of several local and territorial reports, local knowledge of the main issues facing Sahtu residents, SHSSA Board Members set three priorities for measurable improvement in services and health.

2014 TO 2016 STRATEGIC PRIORITIES TO ACHIEVE OUR MISSION:

- ✓ By March 31, 2015, 50% of people and families are highly satisfied with care and services through home care.
  - Move away from care based on task to care based on relationships
  - Move from frustration with services to satisfaction with care and services
  - Reduce barriers to accessing home and community care to services based on assessed needs
  - From inflexible services to flexible services

- ✓ By March 30, 2016, people in Sahtu, who want to deal with their addictions, rate SHSSA care and services as very good or excellent. (20% more than baseline)
  - Care and services were available to me where I was at
  - I was a full partner in my care
  - My culture was acknowledged and supported
  - I was given options that helped me get better

- ✓ By March 31, 2016, people in Sahtu with, or at risk for, diabetes will experience improvement in their health by 50% of baseline.
  - 50% fewer newly diagnosed with diabetes
  - 50% more people with diabetes are successfully self-managing their disease

STEP THREE: COLLECT AND REPORT DATA FOR LEARNING AND IMPROVEMENT

Data will be gathered at the community level on all three strategic priorities for each of the key performance measures. The regular gathering of data will be used for ongoing learning and improvement.

SHSSA Performance Dashboard:

Quality Dimension	Home and Community Care	Addictions	Diabetes
Responsiveness: Care and services were tailored to my needs where I was at	% home and community care clients who rate high level of satisfaction with care and services Target: 50% by March 31, 2015	% clients rate high level of satisfaction with support and services for addiction Target: 20% more than baseline by June 30, 2015	% people with diabetes (or at risk for) rate high level of satisfaction with care and services Target: 50% by March 31, 2015
Effectiveness: I know my health and wellbeing has improved	% home and community care clients with documented health and wellbeing objectives per community. Target: 50% by March 31, 2015 % of home and community care clients with objectives achieved Target: 50% by June 30, 2015	% of clients with documented objectives Target: 50% by March 31, 2015 % of clients with at least one objective achieved Target: 50% by June 30, 2015	% of people with diabetes with documented self-management goals Target: 50% more than baseline by March 31, 2015 % of clients with at least one self-management goal achieved Target: 50% more than baseline by March 31, 2015
Value from Relationship with SHSSA The support I received helped me achieve my goal	% of clients able to identify one example where support from SHSSA contributed to their personal goal for health or wellbeing. Target: 50% by March 31, 2015	% of clients able to identify one example where support from SHSSA contributed to their personal goal for health or wellbeing. Target: 50% by March 31, 2015	% of clients able to identify one example where support from SHSSS contributed to their personal goal for health or wellbeing. Target: 50% by March 31, 2015

REDESIGN HOME AND COMMUNITY CARE

Background to the Opportunity for Improvement

- Front-line staffs report that additional employees are required to meet current homecare client needs. Current workload data does not support this. Sahtu community leadership reports that SHSSA is not meeting homecare needs in each of the 5 communities.
- Independent review of home and community care services in each of the five communities showed there is opportunity for significant improvement in home and community care services.
- Variation in services provided in the home are largely based on what the local home support workers are willing or able to do for Elders.
- Home support workers carry out specific tasks in a subset of elder's homes without any oversight or supervision by nursing or other SHSSA staff.
- Expectations of the community reflect the legacy of homemaking services provided by the band and determined by the chief and council of each community prior to SHSSA assuming responsibility for home care services. Historically chief and council determined eligibility for assistance with homemaking based on age. Many elders in each community continue to feel they should get homemaking support based simply on their age.
- There is variation in the core services provided in each community. Modest light housekeeping support is available in 3 of 5 communities. Meal preparation is only offered in Deline. Medication delivery and transportation are services found in all five communities. Deline offers weekend home support workers where the other communities do not. Laundry services are provided by staff in Colville Lake but not light housekeeping. Assistance with weekly bath is provided at the health centre in Deline, and Tulita. Home support workers in Tulita do not provide any light housekeeping support.
- Transportation of elders to the clinic or for groceries or socialization is appreciated by those that receive this support and resented by elders who don't get this assistance.
- The stated process for initiating home care services is a referral by anyone to the nursing staff at the health centre. A registered nurse then is supposed to complete the Continuing Care Assessment and Placement Form (CCAP). The form and assessment process that goes with this form is designed for someone being assessed for placement into long term care. Its labour intensive and if done correctly, far too detailed for planning care for home care services. There is expectation that the CCAP is initiated upon admission to home care but not fully completed.
- Within the stated standards of the home and community care program there is the expectation of a Case Conference where the Client Service Agreement is signed by the client, a family member and the nurse assessor. From this agreement, the tasks assigned to the home support worker are determined. It's not clear how the family responsibilities are determined or conferred. A home care plan is a list of tasks. A nursing care plan or client centred care plan with objectives is lacking in practice.
- Care reassessment is expected to be done annually or if there is a change in health status. Reassessment is supposed to be documented on client's CCAP form. In at least one health centre the reassessment and CCAP documentation was based on a

conversation between a nurse and the home support worker. A visit to the home by the nurse is not required in the reassessment process.

- In part due to the work of the home support workers being organized around tasks and schedules and little or no follow up by nursing staff in the homes, medications are being dispensed at higher volumes than being taken by clients in their home. A large box full of inhalers and diabetic medications that were not being taken by a home care client was presented to the board at their regular meeting. The box highlights a problem that exists in many homes in all of the communities. Clearly an opportunity for learning and improvement.

PROBLEM STATEMENT

Current Home Care Services in SHSSA are inadequate to meet the needs of an aging population with sometimes multiple physical, social and emotional issues. There is a heavy reliance on the home support worker staff that has very little training or experience in health assessment or adequately trained or supported to respond when a change is needed. Nursing, medical, social work and mental health counsellors are visibly absent from any home care plans or clients. If home care clients are seen by allied professionals, their care is often uncoordinated with services provided in the home. The form and processing for assessing and reassessing people's care needs through the home care program is cumbersome and inadequate. Home support workers are largely left on their own to sort out their small case loads. This independence and lack of accountability to the community and the rest of the health and social services staff means these employees are opting for their preferred work of transportation and friendly visits. Medications are being dispensed at far higher volumes than being taken.

Home support workers documented time spent providing care indicates staffs is working at approximately fifty percent of time available. Given this data is only collected for home care staff; it is not known what the rest of the SHSSA staff's productive time would yield. The data suggests, however, there is opportunity to increase care and services in the home without need for more staff.

RECOMMENDATION

The SHSSA Board of Directors set an ambition aim for transforming home care services in Sahtu:

- ✓ By March 31, 2015, 50% of people and families will be highly satisfied with care and services through home care.
  - o Move away from care based on task to care based on relationships
  - o Move from frustration with services to satisfaction with care and services
  - o Reduce barriers to accessing home and community care to services based on assessed needs.
  - o From inflexible services to flexible services.

Home and community care needs to be seen as a high priority for significantly improving health and care experience for elders and people with chronic illnesses. Home and community care offers the greatest potential for significantly improving the conditions for living that support health and wellbeing. Resourcing home care by redirecting time and work of nurses, social workers, mental health counsellors, Community Health Representatives, Wellness workers and home support workers to collaboratively improve care and services to people in their homes will significantly reduce sick clinic visits and consequent polypharmacy currently the norm in each community.

Integrated Service Delivery Model has been a quest of the Territorial government for health and social services for many years. There is a tremendous opportunity to redesign and improve care and services using an integrated care team model within home and community care.

The assessment process and form must be redesigned to reflect an interdisciplinary approach to care planning. Client/family specific goals and objectives should be based on what clients and families determine are the highest priorities. Ongoing reassessment should be based on client/family goals and objectives not on an arbitrary standard of one year.

'Friendly visits' should be avoided as an assigned task of a home support worker. The Sahtu are communal people who only recently moved to living in single family dwellings in villages. The isolation created by single family housing is a problem for many elders. Resources and energy should be invested in elder day programs, community lunches, and community social gatherings with multiple generations participating. SHSSA should direct their staff in each community to partner with other agencies in the community to make these programs possible and sustainable.

Providing transportation for elders is also a service in need of redesign. A large portion of home support worker's time is spent picking people up to bring them to the clinic or dropping them home again. If SHSSA staff recognized the benefit of assessing people in their own homes as a key feature of their assessment of health and wellbeing, there would be far less time spent in transporting people to appointments. Visibility of SHSSA staff out in the community would also improve relationships between professional staff and community members.

Transporting elders, preparing meals for elder gatherings, cleaning water tanks, chopping wood need to be supported within the community by the community. Extrinsic rewards are currently undermining intrinsic motivation. Social cohesion within each community needs to be restored. Service to elders may be one way to restore harmony and mutual respect that has dwindled.

REDESIGN ADDICTIONS SERVICES

Background to the Opportunity for Improvement:

Alcohol and drug addiction affects just about every family in the Sahtu region. Heavy drinking classified as 5 or more drinks in the past month age 12 and older is nearly double for the NWT population as compared to the rest of Canada (2012 31.7% NWT compared to 17.4% Canada).

Mental health and addictions leadership estimate less than 20% of people who seek help for alcohol or drug addictions are able to achieve sobriety with current approaches to care and services. There are no treatment programs in NWT at present. People who do go south for treatment struggle to remain sober when they return to the community.

Current care and services for people with addictions are mostly one to one approaches between counsellor and client. Given the social nature of alcohol use, it is surprising how very little efforts at changing the social conditions within which excess use of alcohol and drugs are the norm exists in the communities.

Board members spoke about their individual efforts to change the course of their addictions and the support they needed from professionals and family to achieve sobriety. The board would like to see expansion of addictions services to include a broader network of community people who have achieved personal sobriety and are ready to help others. Changing social norms and social conditions are key to long term success at measurably reducing addictions and the numerous social problems associated with alcohol and drug use. Care and services for people with addictions need to have a community focus.

PROBLEM STATEMENT

Current approach to addictions treatment and support has very low rate of success. People with addictions receiving treatment need additional community supports to improve outcomes. Social cohesion is a problem in the communities. Efforts are required to increase supportive networks within the community to achieve more sustainable solutions for the longer term.

RECOMMENDATION

The board set a strategic priority for addictions focusing on person's experience with care and services.

- ✓ By March 30, 2016, people in Sahtu, who want to deal with their addictions, rate SHSSA care and services as very good or excellent. (20% more than baseline)
    - Care and services were available to me where I was at
    - I was a full partner in my care
    - My culture was acknowledged and supported.
    - I was given options that helped me get better.

REDESIGN DIABETES CARE

Background to the Opportunity for Improvement

The prevalence of diabetes in the Northwest Territories population continues to grow. An aging population with higher prevalence of obesity in both the adult and youth population suggests this trend will continue into the future. Chronic disease management best practices have made significant advances in recent years. The good news is with comprehensive, integrated team based support to self-management for people with diabetes also contributes to other health benefits and reduces complications of other related conditions – Cardio vascular disease, hypertension, and cancer for example.

Tulita was a pilot site for 'The Better Project' and staff in Norman Wells health centre have been emphasizing self-management in their care of persons with diabetes. Support exists from the Territorial Department of Health as well as SHSSA for 'The Better Project'.

PROBLEM STATEMENT

Diabetes is a serious and growing health problem for the people of Sahtu. It behooves SHSSA to focus on measurably improving health outcomes and reduce complications among people with diabetes. It is equally important to reduce the new cases of diabetes (incidence rate) by exploring population level opportunities to increase physical activity, reduce calories from sugar and support healthy eating.

RECOMMENDATION

SHSSA Board of Directors set an ambitious aim to significantly reduce new cases of diabetes and support people with the disease to find what works for them in managing their diabetes better.

- ✓ By March 31, 2016, people in Sahtu with, or at risk for, diabetes will experience improvement in their health by 50% of baseline.
    - o 50% fewer newly diagnosed with diabetes
    - o 50% more people with diabetes are successfully self-managing their disease.